No. 081041

IN THE WEST VIRGINIA SUPREME COURT OF APPEALS

IN THE MATTER OF:

ERNIE L. BOWERS,

Petitioner,

v.

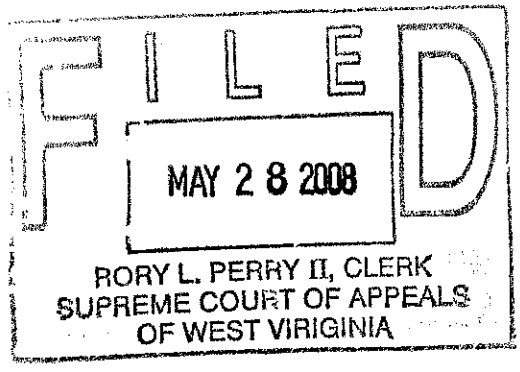
Claim No. 2003012501
Appeal Board No. 2036685

LIGHTNING CONTRACT SERVICES, INC.,

and

OFFICE OF THE INSURANCE COMMISSIONER OF WEST VIRGINIA IN ITS CAPACITY AS ADMINISTRATOR OF THE OLD FUND,

Respondents.



BRIEF OF THE OFFICE OF INSURANCE COMMISSIONER IN RESPONSE TO THE CLAIMANT'S PETITION FOR APPEAL

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May 28, 2008

TABLE OF CONTENTS

TABLE OF AUTHORITIES

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BRIEF OF THE OFFICE OF INSURANCE COMMISSIONER[1] IN RESPONSE TO THE CLAIMANT'S PETITION FOR APPEAL

I. STATEMENT OF THE CLAIM

This claim comes before this Court pursuant to the claimant's petition for appeal from the March 26, 2008, decision of the Workers' Compensation Board of Review. (Exhibit 1). This decision affirmed the February 5, 2007, decision of the Office

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[1] On December 31, 2005 at 11:59 p.m., pursuant to West Virginia Code §§ 23-2C et. seq., and a proclamation of the Governor, the Workers' Compensation Commission was terminated. West Virginia Employers' Mutual Insurance Company, d/b/a BrickStreet Mutual Insurance Company, a private employer mutual insurance company, is now the sole provider of workers' compensation insurance in West Virginia for all claims with a date of injury of July 1, 2005 and thereafter. All earlier claims, such as the claim in issue here, remain a State of West Virginia obligation in what is statutorily referred to as the "Old Fund." The Old Fund is administered by the Insurance Commissioner. The Insurance Commissioner in its capacity as Administrator of the Old Fund is the real party-in-interest here. This pleading will refer to the Insurance Commissioner as Administrator of the Old Fund as the "Commissioner" when referring to events before and after January 1, 2006. This response is that of the "Commissioner."

of Judges (Exhibit 2), which had itself affirmed the October 3, 2006, corrected decision of the Claims Administrator denying the addition of depression (311) as a compensable condition in this claim. (Exhibit 3). For the reasons set forth below, the Commissioner requests that the claimant's petition be denied, and the March 26, 2008, decision of the Board of Review thereby be affirmed insofar as it upheld the denial of the addition of depression.

II. STATEMENT OF FACTS

The claimant is a 57 year old former mechanic and electrician who injured his neck and back when attempting to lift a heavy motor while working for Lightning Contract Services on July 12, 2002. His family physician, Dr. Richard Trenbath, diagnosed left sacroiliac joint and lumbosacral strain, and the claimant initially received conservative treatment. Eventually, Dr. Julian Bailes, with WVU, performed anterior cervical microdiscectomy with fusion at the C6-7 level in January, 2003.

Dr. Joseph Fernandes, M.D. evaluated the claimant on September 17, 2003, and diagnosed the claimant as Status-post C6-7 microdiscectomy, osteophytectomy and fusion; Herniated L4-5 disc on the left side; and Degenerative disc disease cervical and lumbar spine, pre-existent. (Exhibit 4). Dr. Fernandes concluded that the claimant had reached maximum medical improvement regarding his cervical spine, and recommended 15% whole person impairment.

Two years after the compensable injury, Dr. Trenbath evaluated the claimant on April 27, 2004, and reported in his office notes that the claimant had a depressed affect, and that he had depression due to his pain complaints. Rather than request that Workers' Compensation add depression as a compensable condition, Dr. Trenbath indicated that he was going to try to find "some samples" of medication to give

him. The doctor neither requested to add depression as a compensable condition in the claim, nor did he refer him to a psychiatrist.

On May 24, 2006, two years after the above report, and four years after the date of injury, Dr. Trenbath requested that depression be added as a compensable component in the claim due to the claimant's loss of appetite, insomnia, flat affect and loss of interest in activities. (Exhibit 5). Again, Dr. Trenbath did not refer the claimant to a psychiatrist.

Marsha L. Bailey, M.D., with the Office of Medical Management, evaluated the claim on July 11, 2006. (Exhibit 6). She was "hesitant to add the diagnosis of major depression to this claim with such scant documentation nearly four years after the injury," and her recommendation was to deny the claimant's request.

On July 28, 2006, the Claims Administrator denied the claimant's request to add depression. (Exhibit 7). This Order was corrected on October 3, 2006, wherein the Claims Administrator again denied the claimant's request, and explained that the request was denied due to the OMM review and per Title 85 § 20.12.2a. The claimant protested this denial to the Office of Judges.

By Order dated February 5, 2007, the Office of Judges affirmed the Claims Administrator's denial. In that decision, the Administrative Law Judge concluded that the evidence presented did not meet the standard set forth in Title 85 § 20.12.2a requiring that symptoms of an injury related psychiatric diagnosis must manifest within six months of injury or significant injury related complication. The claimant appealed to the Board of Review.

On March 26, 2008, the Board of Review affirmed the Office of Judges' denial, and the claimant now petitions this Honorable Court to hear his appeal.

III. STANDARD OF REVIEW

West Virginia Code §§ 23-5-15(c) and (d) set the standard for a review of a decision by the West Virginia Workers' Compensation Commission Board of Review by the Supreme Court. The statute says the Supreme Court can reverse or modify the decision if it finds the decision was either (1) in clear violation of a constitutional or statutory provision or (2) clearly the result of an erroneous conclusion of law. On questions of law, therefore, the standard is de novo.

On questions of fact, the standard varies depending on the pattern of the rulings below. If the Board of Review's decision effectively affirmed the rulings of ***both*** the Office of Judges and the Commission – as it does in this case – then the standard of review is very limited. The Supreme Court can reverse or modify the Board's decision only if it finds the decision was based on a material misstatement or mischaracterization of particular components of the evidentiary record.

If the Board's decision effectively represents a reversal of the decision of either the Commission or the Office of Judges, then the standard of review is different, but still limited. The statute says in this circumstance, the Supreme Court can reverse or modify the decision only if it finds the Board's findings were so clearly wrong based on the evidentiary record that even when all inferences are resolved in favor of the Board's findings, reasoning, and conclusions, there is insufficient support to sustain the decision.

In either factual situation, the Court, "may not conduct a de novo re-weighing of the evidentiary record."

IV. QUESTION PRESENTED

Whether the Board of Review's decision was based on a material misstatement or mischaracterization of particular components of the evidentiary record.

V. ARGUMENT

West Virginia Code § 23-4-1g provides that the resolution of any issue before the Office of Judges shall be based on a weighing of all evidence pertaining to the issue and a finding that a preponderance of the evidence supports the decision reached by the Administrative Law Judge. W. Va. Code § 23-4-1g (2003). The resolution of issues in claims for compensation must be decided on the merits and not according to any principle that requires statutes governing the workers' compensation system to be liberally construed because they are remedial in nature. Id. As the decision of the Office of Judges below properly noted:

> Preponderance of the evidence means proof that something is more likely than not so. In other words, a preponderance of the evidence means such evidence, when considered and compared with opposing evidence, is more persuasive.
>
> With regard to treatment, West Virginia Code § 23-4-3(a) (2005) states:
>
> The commission, and effective upon termination of the commission, all private carriers and self-insured employers or their agents, shall disburse and pay for personal injuries to the employees who are entitled to the benefits under this chapter as follows:
>
> (1) Sums for health care services, rehabilitation services, durable medical and other goods and other supplies and medically related items as may be reasonably required. . . .

Further, 85 C.S.R. § 20.9.1 states:

> The Commission, Insurance Commissioner, private carrier or self-insured employer, whichever is applicable, will pay for health care services, durable medical and other goods and other supplies and medically related items as may be

> reasonably required. The Commission, Insurance Commissioner, private carrier or self-insured employer, whichever is applicable, will only pay for those services or items that have a direct relationship to the work related injury or disease, as determined in the sole discretion of the Commission, Insurance Commissioner, private carrier or self-insured employer, whichever is applicable.

Pursuant to 85 C.S.R. § 20.4.1:

> The treatment guidelines, standards, protocols, and limitations thereon provided for the injuries and diseases listed in this section are designed to assist health care providers in the evaluation and treatment of injured workers. The provisions of this Rule are not intended to strictly dictate results and it is recognized that there may be ***extraordinary cases*** that require treatments in addition to the treatments set forth in this Rule. ***However the treatments and limitations on treatments set forth in this Rule are presumed to be medically reasonable and treatments in excess of those set forth in this rule are presumed to be medically unreasonable***. A preponderance of evidence, including but not limited to, detailed and documented medical findings, peer reviewed medical studies, and the elimination of causes not directly related to a compensable injury or disease, must be presented to establish that treatments in excess of those provided for in this Rule are medically reasonable. To receive reimbursement from the Commission, insurance commissioner, self-insured employer or private carrier, whichever is applicable, for treatment in excess of that provided for in this Rule, all providers must thoroughly document and explain the action taken and the basis for the deviation from this Rule and shall receive authorization before providing said treatment.

(Emphasis added). With specific regard to psychiatric treatment, 85 C.S.R. § 20.12.2.a states:

> "Work injury-related psychiatric disorders" means those psychiatric disorders caused by or aggravated by a work injury or disease. Attached as Exhibit A is a list of psychiatric diagnoses which are, by definition, not significantly contributed to by a work-related injury, unless the disorder ends in the phrase "due to a general medical condition" where the general medical condition is caused

> by the work-related injury. ***In order to be regarded as work-related, symptoms of an injury-related psychiatric diagnosis must be manifest within 6 months of the injury or significant injury-related complication based on credible medical evidence.***

Under West Virginia law, a claimant bears the burden of establishing compensability by a preponderance of the evidence. In this matter, the evidence of record fails to establish that the claimant's depression, if any, is related to the compensable injury. Eighty-five C.S.R. § 20.12.2a, specifically requires that, to be compensable, a diagnosis of depression must be made within six (6) months of the compensable injury. Clearly, such a diagnosis was not made in this claim. Further, in order for any psychiatric diagnosis to be held compensable, the diagnosis must be made by a psychiatrist, and not a physician. There is no psychiatric evidence in this case indicating that the claimant suffers from any compensable psychiatric condition.

In his decision of February 5, 2007, the Administrative Law Judge, noted that the treating physician diagnosed the claimant's depression in April, 2004, more than two years after the claimant's compensable injury. The ALJ stated that "as the physician of record for the claimant since August of 2002, it seems likely that Dr. Trenbath would have been aware of any symptoms of depression that presented themselves within six months of the claimant's injury, but he has offered no evidence of such knowledge." The Administrative Law Judge further concluded that Dr. Trenbath failed to answer the pertinent questions at issue, including why the doctor did not request the addition of depression as a compensable component in April, 2004, if he felt at that time that the claimant was depressed due to the work-related injury; and why there is no medical documentation referencing the claimant's depression during the eighteen months after Dr. Ambroz's IME of November, 2004, and the Diagnosis Update submitted May 24, 2006.

With no reliable answers to the above questions, the ALJ concluded that the evidence of record did not establish that the claimant was depressed as a result of his compensable injury, most notably due to the fact that depression was not even noted by his physician for at least two years after the date of injury, and was not diagnosed for more than four years. To date, the claimant's treating physician has never referred him to a psychiatrist for a more accurate diagnosis and appropriate treatment.

Accordingly, the February 5, 2007, decision of the Office of Judges, insofar as it affirmed the denial of the addition of major depression as a compensable condition, is plainly correct, and was correctly affirmed by the Board of Review. As such, the Commissioner would request that the claimant's petition for appeal be refused, and the Board of Review's decision left undisturbed.

VI. CONCLUSION

For the above stated reasons, the Commissioner requests that the claimant's petition for appeal be denied, and the Board of Review's March 26, 2008, decision thereby affirmed.

Respectfully submitted,

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Workers' Compensation Defense Division
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(304) 558-0708

EXHIBITS

1. Board of Review Order dated 3-26-08;
2. Decision of Administrative Law Judge dated 2-5-07;
3. BrickStreet Corrected Order dated 10-3-06;
4. Report prepared by Joseph E. Fernandes, M.D., dated 9-17-03;
5. BrickStreet Diagnosis Update;
6. BrickStreet Physician Review by Marsha L. Bailey, M.D., dated 7-11-06; and
7. BrickStreet Decision dated 7-28-06.

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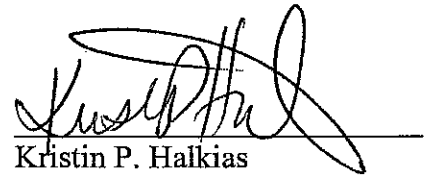
CERTIFICATE OF SERVICE

I, Kristin P. Halkias, counsel to the Commissioner, do hereby certify that a true copy of the foregoing "Brief of the Insurance Commissioner in Response to the Claimant's Petition for Appeal" was served upon all parties of record by depositing same in the United States Mail, first-class postage prepaid, on this 28th day of May, 2008, and addressed as follows:

Linda N. Garrett, Esquire
704 Professional Park Drive
P. O. Box 909
Summersville, WV 26651

Lightning Contract Services, Inc.
P. O. Box 293
Teays, WV 25569



Kristin P. Halkias